

Depression's Effects on Low Income Women

Facts, Issues, Options for Advocacy



Prepared by the Community Outreach and
Public Policy Committee

FACTS

- Prevalence. Depression is an illness that involves the body, mood, and thoughts. In any one year, approximately 9.5 percent of the population will suffer from a depressive illness. (NIMH) Rates of depression among women are 1.5 to three times those of men, and low income women are about twice as likely as higher income women to be depressed (NCCP).
- Symptoms. Depression interferes with normal functioning, and symptoms may include persistent sad, anxious, or “empty” moods; feelings of helplessness and pessimism; feelings of guilt, worthlessness, and helplessness; loss of interest or pleasure in hobbies and activities that were once enjoyed; decreased energy, fatigue, or being “slowed down;” difficulty concentrating, remembering, or making decisions; insomnia, early morning awakening, or oversleeping; appetite and/or weight loss or overeating and weight gain; thoughts of death or suicide, or suicide attempts; restlessness and irritability; persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain. Symptoms of mania include abnormal or excessive elation; unusual irritability; decreased need for sleep; grandiose notions; increased talking; racing thoughts; increased sexual desire; markedly increased energy; poor judgment; inappropriate social behavior (NIMH).
- Types. *Major depression* usually manifests as a combination of symptoms that interfere with normal functioning. Episodes may occur only once, but usually more than once in a lifetime. *Dysthymia* is less severe but chronic, impairing quality of life and often accompanied by bouts of major depression. Individuals suffering from *bipolar disorder* (manic-depressive illness) experience cycling mood swings between severe lows (depression) and sharp highs (mania). (NIMH)
- Causes. There may be a biological (inherited) vulnerability to some types of depression. People who have low self esteem, who are pessimistic about themselves and the world or are readily overwhelmed by stress are prone to depression. (NIMH)
- Poverty. Poverty is one of the most consistent correlates of depression. Among low income people, especially mothers with young children, high levels of depressive symptoms are common. More than one-quarter of welfare recipient mothers met the diagnostic criteria for major depression. Homeless and low income women with housing experienced about two times as high a rate of major depression as the general population of women. (BD)
- Why? Chronic conditions such as those experienced by low income women are more stressful than acute crises and events. They live continually at risk of physical or sexual assault, may experience food deprivation, are subject to humiliating or entrapping severe life events, have inadequate and insecure housing, feel that they are inadequate mothers because they cannot afford child or health care for their children while they work, have poverty-stressed social relationships, and find that their coping strategies are repeatedly inadequate, which contributes to their sense of powerlessness and hopelessness. (BD)
- Other depression-inducing conditions. *Inequality* – being poor in a wealthy environment – and *discrimination* – against a woman’s gender, her race, or her socioeconomic status – have also been shown to be stress and depression producers, and compound the negative mental health effects of being poor. While it is well known that low income is associated with depressive symptoms and poor physical health, it is less often remarked that women of the same income living in a state like Maryland that has high income inequality compared to those in a state where income is distributed more evenly report higher levels of depressive symptoms. (BD)
- Consequences - maternal. Depression in women often occurs after the birth of a child when hormones are readjusting and the woman is likely to feel exhausted and overwhelmed. The more severe the maternal depression, the greater the risk to the infant. In the period between six and 18 months, when babies are most in need of stable attachment to feed the sculpting of their developing brains, they are highest risk. Just when they are needed most, depressed mothers

behave less positively toward their infants, either treating them with anger or disengaging. The infants begin to mirror the depressed behavior of the psychologically unavailable mothers, are less active, vocalize less frequently, and are fussier. As toddlers and children, they begin to have problems with self-control, poor peer relationships, behavioral problems, academic difficulties, and attention problems, and are at greater risk for psychiatric diagnoses later in life. These problems persist even after the mother recovers. (Dawson, Hessler, Frey)

- Consequences – employment. Depression may be a barrier to employment, or may limit a woman's ability to keep a job. Depression, however, can also be the **result** of poor-quality jobs, particularly if a woman had been pursuing an education and was forced by welfare reform rules to go to work in a dead end job. Depression can also be triggered by employment loss. (NCCP)
- Treatment. Treatment has improved significantly. Psychopharmacological and psychotherapeutic treatments both seem to work for mild or moderately severe depression, while a combination of drugs and psychotherapy seems more effective for recurrent severe depression. Few studies have specifically focused on the efficacy of treatment for low income populations or women. It appears, however, that it may be useful to address mental health problems in job search programs, and to offer welfare recipients financial incentives to work. (NCCP)
- Access. Despite being at high risk of depression, poor women rarely receive mental health services of any kind. (BD) Income, type of health insurance, ethnicity, and gender affect the treatment received. Individuals with low incomes are less likely to receive treatment from mental health specialists such as psychiatrists and psychotherapists; Medicaid beneficiaries are less likely to receive newer forms of antidepressants such as Prozac; and Medicaid beneficiaries are less likely to obtain psychotherapy than are individuals with private insurance. (NCCP)
- Racial disparities. Racial disparities are evident within depressed Medicaid patients. Nonwhite patients receive less optimal treatment than whites. (NCCP) African Americans, who make up slightly more than 28% of the Maryland population, comprise 32% of the uninsured.
- Barriers to treatment of low income people. Barriers to effective treatment include high costs, lack of medical insurance, stigma, poor recognition of depression by physicians, and patient barriers, such as language barriers or mistrust of strangers. (NCCP)

BALTIMORE CITY ISSUES

- Mental health services for low income population. Maryland has a public mental health system (PMHS) for persons with Medicaid or who are uninsured. Access is provided in several ways. A statewide toll free number reaches MAPS-MD 1-800-888-1965. MAPS-MD is the organization responsible for the administration of the PMHS. Care Managers assist the caller with locating a provider. Additionally, each county and Baltimore City has a local agency for managing the PMHS. They are known as Core Service Agencies (CSA).
- BMHS. In Baltimore City the CSA is Baltimore Mental Health Systems, Inc. (BMHS). Services are available to persons of all ages. BMHS's focus has been on expanding the range of services, improving continuity of care, developing new affordable housing opportunities, creating new financing initiatives, and promoting community acceptance and public education.
- BMHS is the manager, funder, coordinator, and local authority for mental health services in Baltimore City. BMHS is not a direct service provider. Mental health services are provided by a network of nonprofit agencies (including general hospitals) and private practitioners. Last fiscal year, almost 30,000 Baltimoreans received mental health services through BMHS, 14,306 0-17 year olds, 4,199 18-21 year olds, 14,106 22-64 year olds, and 336 65+, at a cost of \$138,325,996.
- The percentage of the medical assistance population reached by Baltimore Mental Health Systems, Inc. is one and ½ times that of the state as a whole, and the rate of penetration of mental health services for the uninsured population in Baltimore City is two times that of the state.
- The program offers a wide range of services and service providers. The covered services include: 24-hour crisis help, hospitalization, outpatient therapy, residential rehabilitation, supported living, other community-based outpatient mental health services, residential treatment, rehabilitation services, mobile treatment, and day treatment.
- BMHS is available during normal working hours to speak with individuals who are seeking information on services and providers. Staff at local CSAs are able to identify local supports in addition to those provided by the State. In Baltimore

City Baltimore Crisis Response (BCRI) operates a 24 hour, 7 day a week hotline to take crisis calls. BCRI has mobile crisis teams to respond to requests for rapid response from 7 am to 10 pm daily.

- Most often initial appointments are made at an Out-patient Mental Health Clinic (OMHC) through referral from other service agencies, such as Department of Social Services, Parole and Probation, Juvenile Services or one's primary care provider. At the OMHC an assessment by a mental health professional is conducted. This assessment will include an individualized treatment plan. Referrals to other services will be made if the individual meets medical necessity and is willing to accept the referral.

ADVOCACY OPTIONS

- Ask any candidate running for office who seeks your contribution what he or she has done or plans to do to address the mental health needs of low income women. Look to the following organizations for advocacy agendas focused on mental health:
- Black Mental Health Alliance, 733 W 40th St., Baltimore, MD 21211, 410-338-2642, contact: Tracy Bryant, Executive Director
- Maryland Coalition of Families for Children's Mental Health, 10632 Little Patuxent Parkway, Columbia, MD 21044, 410-730-8267, contact: Jane Walker, Executive Director, www.mdcoalition.org
- Mental Health Association of Maryland, 711 W 40th St, Suite 458, Baltimore, MD 21211, 410-235-1178, contact: Linda Raines, Executive Director, www.mhamd.org, see policy priorities at: <http://www.mhamd.org/policy/policygoals.html>.
- NAMI of Metropolitan Baltimore, 5201 York Rd., Baltimore, MD 21212, 410-435-2600, contact: Kate Farinholt, Executive Director, www.nami.org/sites/namimetrobaltimore
- On Our Own of Maryland, 1521 S Edgewood St., Suite C, Baltimore, MD 21227, 410-646-0262, contact: Mike Finkle, Executive Director, www.onourownmd.org
- The Maryland Citizens Health Initiative has developed a comprehensive plan for achieving health care for all Marylanders. The plan and its history, implementation progress to date, and current advocacy opportunities can be found at www.healthcareforall.com.

SUGGESTED READINGS

**Darkness Visible*, William Styron

Books by our speaker Dr. Ray DePaolo and others at Johns Hopkins School of Medicine:

- **Understanding Depression: What We Know and What You Can Do About It:* J. Raymond DePaolo Jr., MD, and Leslie Alan Horowitz
- **An Unquiet Mind: A Memoir of Moods and Madness:* Kay Redfield Jamison, Ph.D
- *Depression, the Mood Disease, Third Edition:* Mondimore, Francis Mark, MD

Books on depression recommended by NAMI:

- *The Childhood Depression Sourcebook*
- *The Depression Sourcebook*, Brian P Quinn CSW, PhD
- *The Ghost in the House: Motherhood, Raising Children and Struggling with Depression*, Tracy Thompson
- *On the Edge of Darkness*, Kathy Cronkite
- *Overcoming Depression*, Demetri Papolos, MD
- *Sorrow's Web: Hope, Help and Understanding for Depressed Mothers and Their Children*, Anne Sheffield
- *You Mean I Don't Have to Feel This Way?* Collette Dowling

*Recommended by a Circle member.

SOURCES: Belle and Doucet (2003) *Psychology of Women Quarterly* (BD); Dawson Hessel, Frey, "The Effect of Maternal Depression on Infant/Toddler Emotional Development," *Sausalito: WestEd*. (1994); National Institute of Mental Health website (NIMH); Lennon, Blome, English (2001) *National Center for Children in Poverty (NCCP)*

March 8, 2007